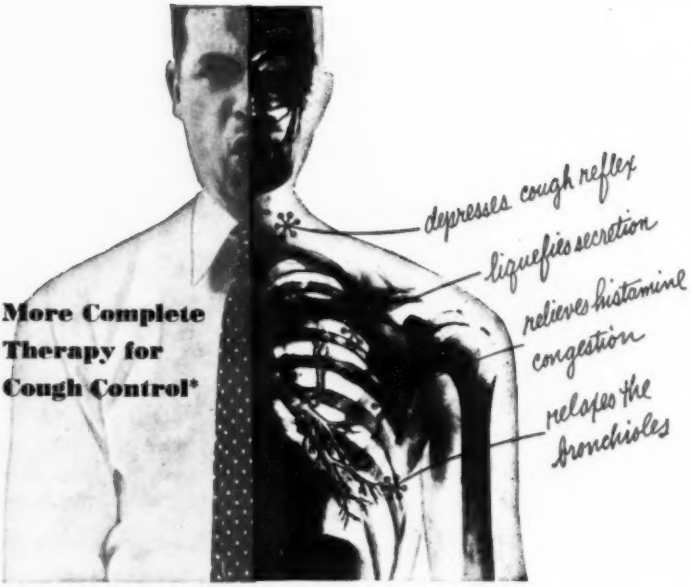
for the family physician

CLINICAL MEDICINE

VOL. 57 OCTOBER, 1950 NO. 10

Original Articles

Editorials



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CLINICAL MEDICINE

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EDITORIAL

The Task Ahead

by FREDERIC R. STEARNS, M.D., *Editor*

The development of medicine in the last five decades, has lead to increasing specialization not only into branches of medicine but even within these branches. This specialization was a necessary consequence of the accumulation of detailed knowledge and specific technics in all ramifications of medicine. As inevitable as this evolution was—as clear became its disadvantages, even to the specialist himself. A sick person constitutes a whole; not the stomach, the lungs or the uterus are diseased, not the cardiovascular system or the central nervous system, but the entire person always reacts physically and emotionally to a pathological agent. The specialist soon became aware of these shortcomings of specialization. The result was that groups of specialists practiced together; the Clinic emerged. It is evident that the compilation of specialistic diagnostic and therapeutical methods at a certain time will provide a relatively total diagnostic view and comprehensive therapeutical procedures on a patient. We wish to stress the concept "at a certain time." This means, briefly expressed, that a clinical examination gives a total "vertical" survey of a patient's condition. The most skillfully taken history can never be more than a secondary means of information conditioned by the present circumstances of both the patient and his relatives; reports on the part of previously attending physicians, too, are generally only abridged responses to special inquiries.

What no Clinic and no specialist can afford is which one might call the "longitudinal" observation of a patient: the follow-up of an individual from birth through infancy, childhood, adolesence and adult life can be done only by the family physician. He alone is familiar with the genetic encumbrance, with the environmental factors, with the developmental dynamics, with the occupational risks, with the social implications, with the climatic conditions and with the peculiarities of the community life which all affect the individual. This knowledge is essentially important and cannot be substituted by the most elaborate clinical diagnostic methods as it alone gives the indications of the constitutional and dispositional patterns, of the general resistance to stress, of the tendency for special pathological reactions, of predominating bents to singular emotional disorders, etc. Therefore, the family physician has always in his mind a patient's "longitudinal totality"; on special occasions he may deem it necessary to have a patient's "vertical" totality checked, and then he will suggest examination by a group of specialists. There are certain medical measures, however, which will remain reserved to the family physician. This is particularly: 1) preventive medicine, as neither vaccinations nor mass x-ray examinations nor periodical specialistic examinations can replace the intimate familiarity of the general practitioner with the genetic, developmental, homeostatic and emotional hazards

of his patients; 2) his influence on the environment of a patient in the family setting, the school, the occupation and social surroundings; 3) his understanding authority which he can exercise in sexual conflicts of adolesence which frequently play a determining role in the emotional and mental development of an individual; 4) his immediate presence in all acute diseases and all medical emergencies; 5) his sway on local institutions and charitable organizations in his community which may alleviate the fate of the aged, the crippled, the economically helpless and the incurables.

This is only an incomplete enumeration of the unique vantage points of the family physician which places him in a not less important position than that of any expert in a special field of medicine.

Nowadays the family physician's significance has become greater not only in the purely medical sphere but also in medical economics. In organized medicine, whether we call it socialized medicine or centrally planned medicine, the family physician as observer of the longitudinal life line of an individual will cease to exist. Even the free choice of the physician in such a planned system will not make good for this loss of an entire field of medicine. In a planned system the physician has neither the time nor the opportunity to be a family physician; he always will be a "case" physician. The strongest argument against centrally planned medicine is the fact that "longitudinal" observation and treatment are by far more important. The family physician is the bulwark against socialized or otherwise planned medicine, the bulwark of individualism against mechanization and equalization.

That is why this Journal has a special task to perform. It will emphasize the significance of the family physician for the health of the Nation. As the family physician generally has not sufficient time and opportunity to read extensively because of his daily toil, this Journal will be a source of information on all those new methods in diagnosis and treatment with which the family physician should get acquainted and which he can employ in his field of activity. We shall bring this information in a concise and well selected way so that the general practitioner will get the information, useful to him, within a short reading time. We shall be supported in our endeavor, to bring the worthwhile, by reputed specialists in all fields of medicine so that the reader may be sure of the confirmed practical value of our material.

ORIGINAL ARTICLES

Nutritional Deficiency

by SIDNEY VERNON, M.D., F.A.C.S., F.I.C.S.

It may seem incongruous to look for deficiency states among normal persons in the "land of plenty". Yet, paradoxically enough, clinical deficiency is more likely to show up in the well fed person following an acute deprivation, of ingestion or absorption, or dietary imbalance as usually evident in prolonged chronic starvation.

A high economic standard also produces a demand for consistent maximum well-being. This places a responsibility on the physician for early detection and correction of pathology resulting from malnutrition. Deficiency disease often appears in the stocky well developed and "well padded" individuals to surprise the medical attendant.

Deficiency is detected by history and physical examination, but clinical discoveries are made by looking for them. The value of a routine physical examination depends on the alertness of the examiner primed to evaluate minor variations in the skin and mucous membranes, as well as other organs and tissues.

Deficiency state may be a "hole in the dike" from which serious disease development may ensue. A middle-aged patient with recurrent ophthalmia in cold weather escaped difficulty over the years by going to Florida in the winter. An early winter initiated eye symptoms followed by panophthalmitis with the loss of both eyes. A borderline xerophthalmia complicated eyeball infection to produce total destruction. The practice of preventive medicine in any age group depends on the prompt recognition of deficiency symptoms.

The treatment of obesity by diet, a system of controlled starvation, leaves the medical attendant with an obligation to maintain mineral balance as well as to avoid avitaminosis. The importance of "trace" minerals and undiscovered as well as known vitamins must be considered in this connection. The protection of the circulation accomplished by a slimming down process may be cancelled out by damage to the skin, sensory organs or nervous system if deficiency pathology is allowed to develop.

The patient's history and economic status will affect the examiner's index of suspicion. Home fare adjusts to individual desires better than institutional fare; dietary fads or unsupervised reducing regimes may be hazardous. Previous disease or a serious major operation may be significant. Unsatisfactory emotional status or unfavorable life situations may modify ingestion and absorption of food.

A routine examination slanted to uncover nutritional disease must have thoughtful scrutiny of the mucous membranes, eyes, skin, bones, and nervous system. Since my observations as a Japanese prisoner of war is the basis of my experience in deficiency disease it is useful to refer to them here.

Vitamin C deficiency was manifested among Filipinos after about 6 months of short rations by the appearance of spongy fringes along the gum edges. These bled easily

and were so tender that any food ingestion was painful. Some improvement was accomplished by surgical removal of the tender tissue. Scurvy was manifested in American soldiers more by muscle hemorrhages in the thigh or back. Necropsy showed petechial hemorrhages in cardiac muscle in one case.

The greatest incidence of glossitis and cheilosis took place in October, 1942, which must be considered the 10th month of short rations. Fissured lips at the corners, the edges encrusted, were attributed to riboflavin deficiency. Geographic tongue with tender red areas was attributed to pellagra. A mucous membrane effect of pellagra on the large bowel was manifested by diarrhea. When the diarrheal stool had a high fat content, the condition was diagnosed as sprue. Since biotin deficiency (improved by egg yolk ingestion) can also produce geographic tongue it must be mentioned here. Over a period of time a number of cases of pigmented black tongue were noted in men who were not smokers. Since nicotinic acid deficiency produces black-tongue in dogs these observations were considered possibly significant of chronic pellagra.

One frequently observed skin change noted among Filipinos was depigmented, desquamated, nummular patches on the face. They formed a butterfly pattern on the nose and cheeks when they were numerous and confluent. A riboflavinosis was the cause. Dryness of the skin with a leathery quality and keratotic prominent hair follicles was considered due to Vitamin A deficiency. This occurred on the extremities and buttocks.

Subcutaneous adventitious bursae filled with fluid were occasionally seen. This was considered a thiamin deficiency, since that factor is involved in the fluid balance of the body as well as the exudative function of serous membranes, (the latter a matter of speculation).

The occurrence of skin infection and ulceration was an index of hygienic conditions they were more effective if used together with nicotinic acid. (It is worth noting that where geographic tongue develops under sulfonamide therapy it appears to respond to nicotinic acid therapy). A susceptibility to erythema or to sunburn was characteristic of pellagra and it is interesting to note that redheads seemed particularly susceptible to the pellagrous state.

Scrotal dermatitis was frequently observed. It as one of the earliest deficiencies noted and persisted sporadically. Although oral and labial lesions seemed to disappear in the chronically starved, scrotal dermatitis persisted more or less. In mild cases there was only patchy desquamation and itching. In severe cases the skin was red, smooth, dry, the dartos relaxed and a translucent cast of the skin suggested crinkled wax paper. Discomfort was associated with this lesion and, in some cases, edema and marked swelling.

Exactly what deficiency the scrotal dermatitis represents has not been satisfactorily settled. It was supposed that a factor of the Vitamin B complex was involved. This condition and some cases of intertrigo although occurring in apparently well nourished person should be attributed to deficiency and not infection. When the entire scrotum is involved healing usually occurs first at the median raphe. Crude

liver extract and Vitamin B_{12} may be worthy of trial in this condition.

The subjective and objective findings related to the eye are helpful in determining the general status of the individual. The effect of malnutrition on the eyeball is varied and complex. Many PoW's had severe loss of vision which was labeled "nutritional amblyopia". This occurred after about 2 years of imprisonment. Thiamin deficiency causing optic nerve atrophy was considered one explanation. By and large the condition seemed irreversible.

Since this condition did not occurr among PoW's in Europe, it may be that concurrent malaria or dysentery had a deleterious effect. The neurotoxic effect of quinine, (used at one time or other by nearly everyone) may be of some consideration.

The first nutritional eye effects were noted by anti-aircraft gun crews during the Bataan campaign. Increasing fatiguability of visual effort so affected some of the men that 15 minute duty periods became the limit of tolerance instead of several hours. Riboflavin may have to do with this.

Night blindness developed in many evidenced of vitamin-A deficiency, Xerophthalmia also occured. It was characterized by injected conjunctiva and discomfort and was followed by many corneal ulcerations.

The bony changes of malnutrition are important in pediatrics and children's orthopedics. Rachitic symptoms in the ribs, skull, and long bones show evidence of Vitamin D deficiency. A permanent record of youthful malnutrition may be left in the skeleton to reveal itself in roentgen study.

Nervous system effects are observable as mental, sensory or motor changes. While environmental stress uncovered amoral behavior patterns, aberrant personality change with impaired judgment was often associated with pellagra. In fact the dementia of pellagra could be present before other symptoms of the triad (dermatitis and diarrhea) were evident.

The responsiveness of delirium tremens to niacin therapy suggests that alcohol toxicity plus borderline malnutrition combine to cause this psychosis. Where peripheral neuropathy is associated with prolonged alcoholism, thiamin deprivation is considered as the contributing cause. The effect of thiamin deprivation on higher nervous centers produces the syndrome of Wernicke's encephalopathy (ophthalmoplegia ataxia and clouding of consciousness) also known as cerebral beri-beri.

Infantile beri-beri is accompanied by convulsions. This comes from some toxic factor introduced into the nursing infant from the breast milk of the mother afflicted with beri-beri. Cardiac beri-beri is characterized by dilatation, altered sounds, and signs of cardiac insufficiency. Cases of acute cardiac deaths observed among PoW's were considered as combined Vitamin C and B deficiency. This sometimes occurred in acute starvation cases who seemed to be on the mend. It is probable that in these cases severe potassium deficit contributed to the catastrophe. There is a marked potassium loss with the catabolism of starvation. This must be made up when metabolism increases during the build-up period to maintain normal cardiac function. A dependable method for determining potassium loss in the study of electrolyte imbalance is by the electocardiograph.

The lassitude and asthenia accompanying diet restriction for obesity may be treated with potassium chloride. For edema during obesity treatment, ammonium chloride may produce diuresis. In considering mineral imbalance in malnutrition, the importance of trace elements, especially with regard to sensory function, must be borne in mind.

Blood vessel involvement with sensory changes occurs in nutritional melalgia, a syndrome of painful burning feet noted among PoW's in the Orient. This appears to be a panthothenic acid deficiency, although treatment of this deficiency with copper added is more effective than the pantothenate alone.

Malnutrition is accompanied with anemia, which is best treated with copper, trace elements and Vitamin B factors in addition to iron.

In resume, in history-taking one looks for anorexia, fatiguability, neurasthenia, sore mouth, diarrhea, and nervousness. There may also be paresthesis, night blindness, photophobia, and eye irritations. Muscle pains and bleeding gums may be complained of.

The examiner looks for skin patches, nasolabial sebaceous plugs and cheilosis. There may be Vincent's angina and tongue changes — geographic tongue, strawberry tongue, b l a c k tongue, atrophic tongue; also bleeding gums.

Muscle tenderness, poor muscle tone and loss of vibration sense may occur.

Dermatitis may involve the face, hands, scrotum, vulva, and anus. Pigmentation may occur in puffy eyelids and over bony prominences; follicular keratosis may show up on the extremities.

Rickets, anemia, visual fatiguability and corneal vascularization may occur.

Narrative presentation of facts of malnutrition helps to emphasize that these conditions can occur in large numbers. It is well for the physician to be primed and alert to ferret out the sporadic cases that occur in this country where adequate nourishment is the rule and not the exception.

SIDE GLANCES at the HISTORY OF MEDICINE

PATENT DUCTUS ARTERIOSUS

The first known authentic report was furnished by Ciulio Cesare Aranzio (1536-1589), Professor of Anatomy at Bologna, Italy. The first description of a technic for surgical ligation was given by J. S. Munro (Surgery of the Vascular System. I. Ligation of the Ductus Arteriosus. Ann. Surg. 46:335, 1907). However, the first successful ligation was finally performed by R. E. Cross and J. P. Hubbard (Surgical Ligation of a Patent Ductus Arteriosus; report of first successful case. J.A.M.A. 112:729 Feb. 25, 1939).

ORIGINAL ARTICLES

Iontophoresis

by EUGENE EISENLOHR, M.D., Terre Haute, Indiana

Iontophoresis limits itself to the control or harmless stimulation of natural forces and to minimal doses of proven drugs in its aim for restoration of normal conditions. It enables instant medication of localized pathological processes.

In iontophoresis the straight galvanic current decomposes at the active smaller electrode any chemical compound and carries its resulting ions toward their opposite poles. The drugs singularly useful for iontophoreses (The Dispensatory of the U.S.A., 23rd ed.) are: alsol (aluminum aceto tartrate), 5% antiseptic and astringent; ichthammol, 5%, feebly antiseptic and irritant, stimulates peripheral circulation; magnesium sulfate, 25%, anesthetic, stimulates glands of intestinal tract; sodium iodide, 1%, counterirritant, accelerates metabolism, increases glandular secretion; sodium salicylate, 1%, antiseptic, fungicidal, increases kidney elimination of uric and ascorbic acid; zinc sulfate, ¼ to 1%, astringent, irritant, mild caustic.

Indications for iontophoresis: Localized disorders such as chronic fibrosis, muscular rheumatism, arthritis (post-traumatic, gonorrheal, degenerative), hypertrophic, edematous and oversensitive mucous membranes (drugs: magnesium sulfate, ichthammol, alsol, sodium salicylate, sodium iodide); regional lymphadenitis (drugs: magnesium sulfate, ichthammol, sodium iodide); hypothyroidism (sodium iodide, 1-2%); catarrhal laryngitis, acute and chronic (drugs: magnesium sulfate, ichthammol, alsol); laryngotracheobronchitis (drugs as catarrhal laryngitis); localized processes of lungs and pleura (drugs: magnesium sulfate, ichthammol, sodium iodide); pelvic organs (including prostatitis and benign local processes of the female genitals (drugs: magnesium sulfate, zinc sulfate, sodium iodide, ichtahammol, cuprim sulfate); coccygodynia (drugs: magnesium sulfate, alsol,); fissura ani (drugs: first procaine, 2%, than zinc sulfate, 2%,); bursitis (drugs as listed under localized disorders).

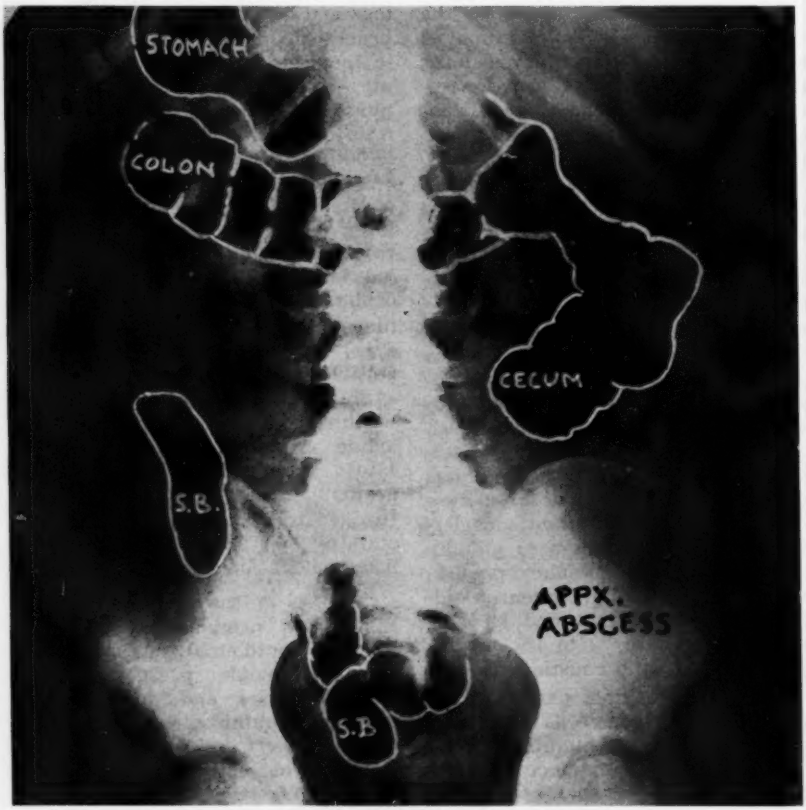
(This is a condensation of Dr. Eisenlohr's original article which contains anatomical, etiological and symptomatologic presentations of the mentioned and an additional number of pathological processes in which he feels that either iontophoresis or other low volt current are indicated).

ORIGINAL ARTICLES

The "Acute Abdomen"

APPENDICEAL ABSCESS

(Joseph Levitin of San Francisco summarized the value of a simple abdominal x-ray or "flat film" for the recognition of acute abdominal lesions in a *Clinical Medicine* article. Because of lack of space, his case reports, with roentgenograms, must be published serially.—Ed.)



Case Number 9

Child of 7 had acute pain in the abdomen with nausea and vomiting, which later localized in the right lower quadrant. Pain later subsided, but the fever continued. She was first seen by a physician six days later. At that time he noted localized tenderness in the right lower quadrant, moderately distended abdomen and a temperature of 101° F. Patient was brought to the hospital. Film of the abdomen showed elevation of the cecum, also displacement toward the midline, and obliteration of the pro-peritoneal fat line on the right side. The diagnosis was made of appendiceal abscess with elevation and displacement of the cecum. This was confirmed at operation.

CASE PRESENTATIONS

A male patient, 41 years of age was first seen on occasion of a general check up in 1947. The family history was non-contributory. The father had died at the age of 72 from myodegeneration of the heart; one sister had died at the age of 18, after a mastoidectomy. The mother was alive with 78 years of age, and apparently healthy; three brothers, ranging from 36 to 50 years of age, were in good physical condition. The patient had never been seriously ill. He had the usual childhood diseases, and he stated that he had been suffering from hemorrhoids for the past 17 years; one doctor had told him that "they were developing into a fistula". The physical examination was essentially negative. He was 5'9" tall and weighed 153 pounds. Heart, lungs, and abdominal organs were in normal condition. The blood pressure was 126 mm. Hg., systolic and 86 mm. Hg. diastolic. The urine specimen showed neither albumin nor sugar. There was a dilatation of the inguinal rings bilaterally, with no evidence of hernia, however. The rectal examination revealed large hemorrhoidal tags; yet no evidence of fistula, past or present. Proctoscopy was not done. About two years after this check up, the patient entered the hospital. He again complained of bleeding hemorrhoids. Hemorrhoids could not be found; yet, there was a small tumor of pea size at the anorectal line. A biopsy was done and adenocarcinoma, Grade II, was histologically diagnosed. Because of the continuous bleeding prior to the hospital admission a rather pronounced secondary anemia was present. An abdominal-perineal resection was performed with construction of a perineal anus. Blood transfusions were given; penicillin, streptomycin, ferrous sulfate and sulfonamides were administered. The patient was discharged from the hospital 6 weeks after operation, with a postoperative sinus tract present. He was readmitted one month later. A diagnosis of pericolonic fistula was made and a fistulotomy was performed. The previous anemia had disappeared. Patient was discharged two days after operation in improved condition. He was again admitted after 2 months. At that time extensive metastases were found. He died after three weeks of palliative treatment.

In the staff conference the question was raised as to the possible connection of hemorrhoids and a later developing malignancy at anus or rectum. It was pointed out that hemorrhoids are found in such a large percentage of the population, that an evaluation as to a probable relationship would be very difficult. L. A. Buie (Postgrad. Med., 177, March 1949, and Practical Proctology, W. B. Saunders Co. Phila. 1937) stated that in a series of more than 23,000 patients examined proctoscopically at the Mayo Clinic about 52% had hemorrhoids at the average age of 48. The Statistics Bulletin No. 1 issued by the Nat'l. Headquarters, Selective Service System gives the incidence of hemorrhoids (and other rectal defects) as 30.6 per thousand; this figure refers essentially to younger age groups. The experiences of the Mayo Clinic again show that in a series of 13,960 patients with hemorrhoids and related conditions, only 2 cases of anal carcinoma were detected. It was also stressed that experiences made abroad, (N. Carstam. Acta Chir. Scandinav. 97:71, 1948-49) proved that hemorrhoids and anal cancer were not related causally. Carstam found hemorrhoids in about 41% of the general

population and no case of carcinoma in a series of routine examinations of hemorrhoid cases; on the other-hand, he found hemorrhoids in almost the same percentage (37%) in a series of cases with anal and rectal carcinoma. The general agreement was that there is no causal connection between hemorrhoids and cancer of anus or rectum.

P.S. Wm. Lieberman (J. Ins. Med. 2:35, March-April-May, 1950) in a careful review of the literature comes to the following conclusion: "With the high frequency of hemorrhoids in the general population, it is interesting to note that as regards the anal canal, rectum and sigmoid only 3% to 10% of the carcinomas of these areas occur in the anal canal and 90% to 95% in the other areas. Primary malignant lesions of the anus, rectum, and sigmoid (Buie, l.c.). It is thus seen that carcinoma arises rarely in the hemorrhoidal site.

Pregnancy and Diabetes Mellitus

A patient of mine is a primipara, in her 2nd month of pregnancy; she has diabetes mellitus which was diagnosed when she was 18; it is controlled by 35 units of protamine zinc insulin in the morning and a dietary regimen. What are your suggestions for the management of the patient and the infant? L.J.G., M.D., Iowa.

Diabetes mellitus is not an easy problem both in pregnancy and as to post-natal care of the infant, particularly in young individuals. The diet should be generous, low fat, high carbohydrate. Single morning injections of protamine zinc insulin should be continued unless there is vomiting; if so, divided doses of crystalline insulin are preferable; this holds true also for the last 2-3 weeks before delivery. It is not essential to bring the blood sugar level down to the normal limit. It is necessary to avoid ketonuria, and diabetic symptoms such as polyuria, pruritis, excessive thirst, etc. Sometimes it is advisable to terminate the pregnancy after the 34th week, particularly when signs of acidosis or toxemia are present. The infant is generally oversized, may show cyanosis, edema, breathing difficulties and, above all, hypoglycemia. Glucose both by medicine dropper and parenterally have been recommended. After 24 hours of such a management most babies do well. (R. A. Reiss. J. Iowa M. Soc. 38:41, 1948—P. White, Chicago M. Soc. Bull, 48:199, Oct. 5, 1946—H. T. Engelhardt and J. P. Melvin. South. M.J. 39:734 Sept. 1946—P. White, J. Clin. Endocrin 3:500, Sept 1943—P. P. Ewald, Journal Lancet 65:13, Jan. 1945—W. P. Given; R. G. Douglas and E. Tolstoi, Am. J. Obst. & Gynec. 59: 729, 1950).

Treatment of Frostbite

What is the exact cause and an efficient treatment in frostbites? Chas. R.N., M.D., Indiana.

The initial impairment is a prolonged arterial spasm causing tissue anoxia. The level at which freezing usually occurs seems to be between 24.8° F. and 14° F. Later the arterioles relax, the veins dilate, the phenomenon of sludging takes place which may result in venous thrombosis. Gangrene may set in. In mild cases without thrombosis, restitution of normal circulation with appearance of edema, vesicles, or trophic changes may lead to final recovery,

CASE PRESENTATION

although throbbing and tingling may persist for a long time. In severe cases, without thrombosis, the affected parts may become edematous, the nails may be lost; hypesthesia or anesthesia may be observed while sensitivity to cold persists. When venous thrombosis is present, the frostbite is 'dry' with eventual dry gangrene. All authors concur that tissue loss in frostbite can be avoided by application of heparin (ampules of heparin in Pitkin menstruum, injected subcutaneously, 300 to 400 mg. daily or every second day). Vitamin K also has been recommended (on the average 20 mg.). Calciferol which also had been used, is not without danger and without significant effect. Prevention of infection may be advisable in some cases; it has been shown that sulfamylon hydrochloride is more potent than penicillin. Local heat should never be used. Exercise and massage may be helpful in some instances. (K. Lange and L. Loewe. Surg., Gynec. Obst., 82:256, 1946—R. Greene. J Path and Bact. 55: 259, 1943—H. B. Shumacker, Jr. Wisconsin M.J., 46:317, March 1947—K. Lange; D. Weiner and L. J. Boyd. New Engl. J. Med 237:384, 1947—D P. Wheatley. Brit M. J. 4530:689, 1947—S. T. Anning. Lancet 2:794, Nov. 29, 1947—J. Pichotka and R. B. Lewis Proc. Soc. Exper Biol. & Med. 72:127, 1949)

THERAPEUTIC SUGGESTIONS

Dysmenorrhea

Premenstrually, the treatment consisted of 25 mg. of pyribenzamine; when dysmenorrhoic symptoms started, 50 mg. were administered t.i.d. If no relief was obtained after 30 min. the dose could be repeated, up to a maximum of 6 tablets daily. Most patients required 150 mg. per day. Pain in the breast was not relieved. Dysmenorrhea was relieved in 90% of a private practice group (10) and in 87% of a industrial group (76). "These findings, while not conclusive are provocative and it is hoped that this work will be extended." (D. B. Hoffman. J. Med. Soc. New Jersey, June 1950 pp 287-288)

Range of Antihistamine Treatment

Antihistamines (benadryl, pyribenzamine, antistine, histadyl, thenylene, neoantergen, trimeton, etc.) give relief in about 65% of mild hay fever, uncomplicated by asthma. In severe hay fever cases desensitization is preferable. In asthma the effect is doubtful; a good combination is Hydrillin (Schering): benadryl and aminophyllin; all antihistamines may, or may not, be helpful in cases of urticaria, and pruritus; they are of little effect is allergic rhinitis and allergic migraine. *(S. J. Levin and S. Moss J. Mich. State Med. Soc. 49:207, 1950)*

Analgetic

Tetracaine (pontocaine) hydrochloride, a drug furnished by Winthrop-Stearns Inc., was tried out by the author intravenously for several conditions in which pain or distress are prevalent such as asthma, various pain syndromes, complications of leprosy, neuritis, itching and mon-

or causalgia. The average dose is 10 cc. of 0.25 percent solution administered over a period of about three to two five-minutes. Toxicity is insignificant mostly consisting of slight nausea. Nineteen of twenty patients with arthritis, ten of eleven patients with complications of leprosy, nine of ten patients with muscular strain, all of eleven patients with asthma, and two of eighteen patients with low back pain were improved *(J. S. Horan, Arch. Int. Med. 6:972, June 19, 1950)*

Thrombo-embolism

A new anticoagulant, 4.4 dihydroxydicumarnyl ethyl acetate with the trade name: Tromexan, proved to effect satisfactory results in patients with thrombosis and embolism. Initial doses are 1,500 to 1,800 mg, further daily maintenance doses are 600 to 900 mg. No untoward side effects were noticed. *(G. E. Burke and I. S. Wright. Bull. New York Acad. of Med. 26:264, 1950).*

Bursitis of the Shoulder

The treatment both in acute and chronic cases still varies according to personal experience. X-ray treatment is recommended in the acute stage every third day three to six times and in chronic cases weekly or bi-weekly one treatment, a total of four to six treatments. The result was satisfactory in 83 percent of 61 cases (D. Robinson, J. M. A. Georgia, May, 1950).

Acne

Estrogenic hormones and antibiotics were administered to 384 cases, 175 of which had not responded to x-ray therapy; 94 per cent of these patients were benefited. While hitherto roentgen treatment had been the treatment of choice, it was evident from a control series of 253 cases, treated exclusively with irradiation, that only 60 per cent were lastingly benefited. (G. C. Andrews; A. Domonkos and C. F. Post. San Francisco Session of AMA, June 26-30, 1950).

Urinary Infection

Chloromycetin (Chloramphenicol) has been recommended in bacillary infections of the urinary tract. Initial dose of 2 Gm. in 2 or 4 equally divided doses; a maintenance dose of 0.5 Gm. 5 times daily, was administered in infections of the upper urinary tract, and 0.25 Gm. in infections of the lower portion. Chloromycetin was ineffective in 13 of 24 cases (F. K. Garvey, W. A. Cline and M. Meads. South. Med. J. 43: 85, Feb. 1950); other authors suggest doses of 1 to 15 Gm. daily in divided doses of 0.25 to 0.5 Gm. Because of possible simultaneous involvement of coccal organisms penicillin and sulfonamides also may be required. The infection disappeared in 82% of cases and the urine became free of bacilli in 38% (G. E. Chittenden et al. J. Urol. 62:771, 1949); *aureomycin* was applied in urinary infection due to E. coli, A. aerogenes, P. Aeurginosa, P. vulgaris, Hemol. Staph. aureus and Strept. faecalis, in doses of 2 Gm. in divided doses for 4 to 6 days. Clinical symptoms disappeared in all patients within 24 hours (A. M. Rutenberg and F. B. Schweinburg. New Engl. J. M. 241, Nov. 3, 1949); similar experiences had H. S. Collins and M. Finaldn (Surg., Gynec. & Obst. 89:43, 1949).

THERAPEUTIC SUGGESTIONS

Psoriasis

Psoriasis has always been a very difficult problem in therapeutical respect. External methods are either only palliative or of no avail. (Goeckerman regime, anthralin, infrared rays, pragmatar ointment, ammoniated mercury with coal tar solution in emulsifying ointment, etc.) Internal management includes cortisone (doubtful results), autohemotherapy, typhoid-paratyphoid A and B vaccine, etc.). Recently encouraging reports have been published on the administration of undecylenic acid, starting with 0.5 Gm. t.i.d. and increasing the doses to daily amounts of 10 to 15 Gm. Side-effects may be disagreeable (vomiting, diarrhea, pain in epigastrium.) However, after a few favorable reports, lately less good results have been reported. (B. Russell. Practitioner 164:197, 1950—C. C. Ellis et al. J. Invest. Derm 10: 455, 1948—. H. H. Perlman, J.A.M.A., 7:444, Feb. 12, 1949—H. H. Perlman and I. L. Milberg, J.A.M.A., 10:865, July 9, 1949—T. G. Warshaw, J. Invest. Dermat. 13:209, 1949).

Pelvic Inflammation

Jacob Jacobson of Paris, France, has reported on treatment of chronic ear inflammation in 1929 using a 4.1 percent solution of benzyl cinnamate ester in olive oil. In cases of chronic pelvic inflammation which proved to be refractory to sulfonamides, penicillin, heat treatment and surgery this solution was injected intramuscularly (1cc), a total of eight injections. This method proved to be satisfactory in about two-third of the cases (M. Markowitz and C. W. Vick, Jr., Am. Pract. May, 1950).

Pemphigus Vulgaris

Convalescent serum, 40 cc., intramuscularly, in three day intervals, with later diminishing doses up to a total of 80 to 130 cc., is recommended as an effective treatment of pemphigus vulgaris; furthermore, administration of testesterone propionate or methyl testosterone (25 mg. from two to three times daily to three times weekly) to stimulate nitrogen retention. As supplementary treatment whole blood or plasma may be given, ascorbic acid and rutin in cases where it appears indicated, vitamins and liver, if necessary. To prevent loss of serum into the bullae, pressure dressings are useful. (I. Fisher, Journal-Lancet, 50:18, 1950)

Emergency Treatment of Apoplexy

Oxygen tent; venesection with removal of 300 ml. of blood in hypertension. Sympathetic block at the site of the seventh cervical transverse process, with 10 ml. of 1%, procaine solution, at the side of lesion. G. *de Takats and G. Graupner, Practitioner, 164:242, March 1950).*

Depressive States

Synhexyl (Synthetic Cannabis Indica) has, in doses of 10 to 20 mg. daily, a beneficial effect in otherwise intractable depressive reactions. The preparation is particularly potent for the relief of cases of melancholia and endogenous depression. (C. S. Parker and F. Wrigley. J. Ment. Sc. 96; 276, January 1950).

THERAPEUTIC SUGGESTIONS

Veratrum Viride in Essential Hypertension

Veratrum viride is effective in moderating the arterial pressure in essential hypertension. Overdosage may result in side effects such as salivation, nausea, vomiting, or ven circulatory collapse (usually innocous; antidotes: atropine 0.5 to 1.0 mg. or e-ephedrine 30 to 45 mg., intramuscularly). The preparations used were Vertavis (Irwin, Neis'er & Co., Decatur, Ill.) and Veratone (Parke, Davis & Co. Detroit, Mich.). The systolic blood pressure was lowered more than the diastolic pressure. Continued administration does not cause tolerance or idiosyncrasy. (R.W.Wilkins. New Eng. J. Med. 242:535 April 6, 1950.)—W.S. Coe; M.M.Best and J.M.Kinsman (J.A.M.A. 1:5, May 6, 1950) reported on less favorable results in ambulatory patients who also showed a high percentage of toxic reactions.

Gantrisin

A new sulfonamide which is distinguished by its high degree of solubility (thus, no crystallization in the urine) and its low toxicity. It was administered to 71 children with various types of infection (Lobar Pneumonia, Bronchopneumonia, atypical Pneumonia, bronchitis, Otitus Media, Tonsillitis, Adenitis, Urinary Tract Infections etc.) in a dosage of 0.5 Gm tablets orally (usual dosage 0.13 to 0.19 Gm per Kg. of body weight divided into 4 to 6 doses daily). The results were satisfactory with 7 exceptions: 3 cases of atypical pneumonia, one of nonhemolytic streptococcic pyuria, one of rheumatic fever, one of infections mononucleosis, one of exanthema subitum. (J.A.Bigler and O.Thomas Am. J. Dis. Child 79:785, May, 1950)

SIDE GLANCES at the HISTORY OF MEDICINE

ALLERGY

While the word allergy was coined by C. von Pirquet in 1906 during his investigation on the tuberculin test (Allergie. München. Med. Wohnsch. 53:1457, 1906), the syndrome was known already to medieval physicians. L. Bottalus (Commentarioli duo alter de medici, alter de aegroti numere. Hinc accedit admonito fungi strangulatorii. Apud A. Gryphiam, 1565) wrote: "I knew men who at the smell of roses were ceased with a loathing as to be subject to headaches or sneezing fits or running of the nostrils so that for two days it could not be stopped."

DIAGNOSTIC SUGGESTIONS

Prolapse of Gastric Mucosa

The incidence is estimated as being as high as stomach ulcer. The syndrome occurs most frequently in males between 20 and 50 years of age. Clinically, epigastric fulness, pain at the right upper quadrant, nausea and vomiting were prevalent symptoms. Occasionally the pain radiated to the chest accompanied by a shock-like state so that coronary thrombosis was a factor in diagnosis. In the previous history, severe gastric hemorrhage was found in some cases. The diagnosis can be made only by roentgenographic study which should be made repeatedly as the picture may vary. Characteristic is an umbrella like shadow projecting into the duodenum. (T. G. Rudner, South. M. J., 43:480, June, 1950)

Melanomas and Nevi

One to two per cent of all cancers and twenty per cent of all primary skin cancers are melanomas. The incidence rate is about 2 per 100,000 population in a year. Most melanomas originate from nevi which, therefore, are pre-cancerous growths. The agreement is that all pigmented and non-pigmented nevi at feet, hands, nails and genitals both in male and female, are potentially dangerous; so are nevi located on sides of irritation such as shoulders, belt, garter, brassiere, collar and shaving areas. All nevi which have recently changed in size and color or which scale, bleed, itch or are inflamed or ulcerated should be removed and studied microscopically. It is stressed that one should not use conservative treatment on nevi such as electric desiccation, carbon-dioxide snow, cautery, etc. without first having done a biopsy.

Tuberculosis

There are three bacteriological procedures: 1) the smear, stained for acid-fast bacilli; yet, a positive smear tells nothing of the cultural features and the virulence of the organisms. 2) culture; has considerable diagnostic significance as there is a close correlation between cultural features and virulence in guinea pigs. 3) guinea pig inoculation; is the most satisfactory single procedure in detecting tuberculosis. (L. A. Weed and G. M. Needham. Proc. Staff Meet., Mayo Clin. 15: 430 July 19, 1950)—More than 95% of significant tuberculosis can be detected by use of the proper tuberculin tests. One may use either Old Tuberculin (OT) or "Purified Protein Derivative" (PPD); of the latter two increasing doses should be given. A negative reaction does not completely eliminate the possibility of tuberculosis. No individual should be considered to be a negative reactor unless he has been tested with the second strength of PPD or with an equivalent amount of OT. (G.G. Stillwell. Proc. Staff Meet., Mayo Clin. 15:422, July 19, 1950)

Exercise Test

Instead of ergotamine tartate which has been used in Master's Two Step Exercise Test dihydroergocornine can be employed safely without the possibility of producing anginal symptoms. It has been found that a positive test that stays positive after intravenous injection of 0.4 to 0.5 mg. of the drug points to the presence of an organic heart disease; when the test turns negative after administration of dihydroergocornine the heart impairment is functional. (*L. Pordy et at. Bull New York Acad. of Med. 26:276, 1950)*

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DIAGNOSTIC SUGGESTIONS

Pyloric Hypertrophy

Congenital pyloric hypertrophy is a recognized disease entity in infants. A similar syndrome may occur in adults, probably persisting asymptomatically from infancy. In 70% of the reported cases the onset was between ages 31 and 60. Symptoms vary. In some cases pyloric obstruction may occur without warning. In most cases epigastric distress and vomiting are the outstanding symptoms; vomiting relieves discomfort. Nutritional deficiency is a significant feature in cases of longstanding. Palpable abdominal mass is found only in very few cases. Diagnosis must be secured by x-ray picture. Characteristically, there is a 25 to 50% retention at the end of 6 hours in the stomach. The abnormalties do not disappear after administration of antispasmodic drugs. (J.P. North and J.H. Johnson, Jr., Ann. Surg. 131:316 March, 1950)

Parathyroid Adenoma

The symptoms are varying as to site and degree, as are those of hyperparathyroidism; musculoskeletal; backpain, deformities, fractures, muscular weakness; gastrointestinal: colic, nausea, epigastric pain, polydipsia; urinary: renal colic and calculi, polyuria; miscellaneous: weight loss, paresthesias, deafness. A mass may be present in the neck; yet, the tumor also may be located in the mediastinum, as normal parathyroid tissue often occurs there. Blood reveals high calcium and low phosphorus values. Death may be due to acute hyperparathyroidism or fatal hormone intoxication. (W. Staub; D.M. Grayzel; P. Rosenblatt. Arch Int. Med. 5:765, May 1950—N.M Smith; W.R. Sandusky. South. Surg 15:111 Febr. 1949—B.M. Black. S. G. & O., 1948.

Addison's Disease

To aid the diagnosis of adrenal insufficiency the author uses Millon's reagent to increasing dilutions of urine. When the addition of several drops of the reagent results in a change of color to pink, Addison's disease is probable. The same results have been obtained in hypopituitarism with consequent adrenal insufficiency. The reaction, however, is not one hundred per cent typical of adrenal insufficiency as it also has been positive in hypothyroidism, yet in no other endocrine disturbances. When the reaction is not clearly positive, intake of thyrosine (4 Gm.) may effect definitely a positive or negative result. The reliability of the reaction can be seen in the fact that administration of desoxycorticosterone acetate or extract of the gland renders the reaciton negative (C. Ferrero. Schweiz. med. Wchnschr. 80:179, 1950)

Diaphragmatic Hernia

The symptoms depend upon the organs included in the hernia. Because of the wide variety of signs and symptoms the name 'masquerader of the abdomen' has been given to this syndrome. In almost half of the cases epigastric pain was present. Pain along the left costal margin or back has been described as a common symptom. Substernal pain was a complaint in only 5.6 per cent of cases. Almost 50% of the patients were overweight. Anemia is a frequent finding (hypochromic microcytic type). Roentgenologic diagnosis is of essential importance in the differentiation from peptic ulcer, gall bladder disease, coronary disease etc., (J. W. Strayer Jr. of the Michigan State M. Soc. 48:1257, Oct. 1949).

DIAGNOSTIC SUGGESTIONS

Cerebral Palsy

According to the classification of Phelps and Fay, cerebral palsy does not merely refer to spastic paralysis due to birth trauma. The new classification includes 1) spastic paralysis (cerebral) with the nonspastic and atonic types; 2) athetosis (midbrain); 3) tremors and rigidities (basal ganglia), both the Parkinsonian and the decerebrate types; 4) ataxia, cerebellar and kinesthetic; 5) high spinal spastic (medulla); and 6) mixed (diffuse). The causes are: birth trauma with subarachnoid hemorrhage and softening; effects of Rh factor; cerebral anoxia, asphyxia, edema, hydrocephalus; encephalitis, prenatal virus infections; meningitis; tumors, cysts, hydromas, clots, abscesses; congenital anomalies, angiomas, aneurysms; defects in blood circulatory or spinal fluid mechanisms, Pacchonian filters, subarachnoid pathways; systemic factors that affect the functions of an originally normal brain, such as nephritis, toxins and drugs. Considering this classification there is a community incidence of 84 per 100,000 population in U.S. More than 350,000 children and young adults are suffering from cerebral palsy; when the case of brain injury, "strokes", and similar syndromes are added, the case number in this country is estimated as about 5,000,000. (Temple Fay. Am. J. Psychiat. 3:180, Sept. 1950)

Polyposis of the Small Intestines

"The Authors in 1944 and 1949 have reported in detail ten cases of a syndrome of generalized intestinal polyposis associated with characteristic melanin spots in the mucosa of the mouth and lips, and, at times, in the skin of the face and digits. It is believed that the frequent association of the characteristic melanin pattern with generalized gastrointestinal or small bowel polyposis will, at times, be of diagnostic aid by suggesting the presence of polyps in intestinal areas difficult to study by other methods." Diagnosis of polyposis of the small intestine is difficult because it is inaccessible to endoscopic studies and there are technical obstacles in securing satisfactory roentgenographic visualization. The melanin spots are never generalized or accentuated in the body folds. In each observed case the pigmentation had been noted from early childhood. This syndrome of polyposis and spots is inherited. Among the ten patients there were two families in each of which 3 members suffered from the syndrome (mendelian dominant inheritance). The pigmantation never occurs in polyposis of the colon or rectum. (H. Jeghers; V. A. McKusick and K. H. Katz. Ciba Clinical Symposia, 6:199, July-August, 1950—1) H. Jeghers. New England J. Med. 88:100; 122; 181, 1944 — 2) H. Jeghers; V. A. McKusick and H. H. Katz. ibid. 241:993; 1031, 1949)

BOOK REVIEWS

Evaluation of Industrial Disability

Prepared by the Committee for Standardization of Joint Measurements In Industrial Injury Cases of The California Medical Association and Industrial Accident Commission, State of California. Packard Thurber, M.D., Chairman. 1950. Oxford University Press, New York. 96 Pages. 80 illustrations. Cloth. Price $4.

The main purpose of this book is to demonstrate standard methods for the measuring and reporting restriction of joint movement in industrial injuries and in traumatic conditions of various etiology. The general instructions stress that the measurement "always represents the arc of voluntary motion of the joint and is shown by degrees." The ranges of joint movement are measured by protractors, the muscular strength by dynamometers. Pain may be subjective (superficial, deep etc.) or objective, as expressed in hyperesthesia, paresthesia etc. As to the general abnormalities and deformities, angulation, spinal curvatures, joint enlargements, tissue loss, contractures, and circulatory disturbances are of importance. The author then describes special sites of impairments, with clearly illustrated examining methods: neck, spine, upper extremity, (shoulder, elbow, forearm, wrist, thumb, fingers), lower extremity (hip, knee, ankle, foot, toes). Finally special disabilities are briefly pointed to, such as ocular and auditory disorders, residues of head injuries, and mental and emotional disability. This latter subject has been dealt with in four lines, which is obviously not in proportion to its importance. Essentially this book is an excerpt of the minutes of the meeting of the Industrial Accident Commission of February 14, 1949; This may explain the emphasis on some, and the brief mentioning of other topics in this field, and also the omission of literature references.

In the whole, this book is a good guide for all general practitioners concerned with industrial injuries and problems of compensation. F.R.S.

Human Fertility

By Edmond J. Farris, Ph.D., Executive Director, Associate Member, Wistar Institute of Anatomy and Biology, Philadelphia. White Plains, N,Y.: The Author's Press. 1950. $5.00.

A thoroughly practical text on the sterility problem and what to do about it. The author does not use the text as an opportunity of displaying his skill or ability to write but as a medium for furnishing exact information to the physician who has not had the opportunity of keeping up the recent advances.

The section on obtaining of a sample by masturbation is of definite value to the examiner who wishes to obtain an uncontaminated, uninjured semen specimen.

Throughout the approach is that of a direct, terse description without padding or bibliographical surplus. This is a book that the physician can use, can increase his understanding of the problem.

Preventative and Corrective Physical Education

By George T. Stafford, Ed. D., Professor of Physical Education, University of Illinois, Urbana, Illinois, New York: A. S. Barnes and Co. 1940. $3.75.

The conscientious physician will do well to glance at such a text as this now and again as an antidote to prescribing medicine for every pain and ache

BOOK REVIEWS

in the body. Poor posture, unhygienic attempts at meeting life's work and play, result in symptoms. The physician should first think of correct physiology rather than of disease.

The book is clearly written, complete and of value for the physician, his intelligent patient, the physical educator and correctionist.

Mobilization of the Human Body

By Harvey E. Billig, Jr., M.D., F.I.C.S. and Evelyn Loewendahl, M.A., Ph.T. Stanford University Press. 1949. $2.00.

A fusion of physical education, physiology of body function and orthopedic freeing of function by exercise results in a small text that will be of interest to all physicians. The attractive model poses depict clearly the positions and motions to be used.

The Physiology of Tissues and Organs

By Douglas H. K. Lee, M.D., Professor of Physiological Climatology, Johns Hopkins University, Baltimore, Maryland. Springfield, Illinois; Charles C. Thomas. 1950. $4.00.

To the practitioner who wishes to review his physiology readily and to the student who wishes to learn the fundamentals of physiology, this little text will be a blessing. The author has made physiology brief, clear and interesting, a welcome contrast to the huge tomes otherwise available. The illustrations are helpful.

Clinical Orthoptic Procedure

By William Smith, O.D., Associate Instructor in Optometry and Instructor in Orthoptics and Visual Training, Massachusetts School of Optometry, Boston. St. Louis: The C. V. Mosby Co. 1950. $8.00.

The author has very well presented orthoptic technics and procedures as verified on the patient. The methods suggested are proved, readily understood and not too difficult of execution: Nonsurgical, pre and postsurgical treatment methods of all types of anomalies of the extraocular muscles and binocular perception are presented in logical fashion. Theoretical material is excluded.

SIDE GLANCES at the HISTORY OF MEDICINE

MULTIPLE SCLEROSIS

The first case was described anatomo-pathologically by Carswell in 1837. Rindfleisch (Virchows Arch. f. path. Anat., 26:417, 1863) gave the first account of the topography and morphology of the plaques in the central nervous system. J. M. Charcot established the famous diagnostic triad of scanning speech, intention tremor, and nystagmus (Leçons sur les maladies du système nerveux. Paris. A. Delahaye & Lescrosmer, 1886, p. 189). The frequent loss of abdominal reflexes was first described by Strümpell (Neurol. Centralblatt. 15:964. Nov. 1, 1896).

BOOKS RECEIVED

Books reviewed or listed in these columns will be procured for our readers if the order, addressed to CLINICAL MEDICINE, 1232-36 Central Ave., Wilmette, Illinois, is accompanied by a check for the published price of the book.

THE TRUTH ABOUT YOUR EYES

By Derrick Vail, M.D., *Head of Department of Ophthalmology at Northwestern University*—Farrar, Straus and Co., Inc., 1950, $2.50

THE PHYSICIAN EXAMINES THE BIBLE

By C. Raimer Smith, B.S., M.D., D.N.B., *General Practitioner*, Philosophical Library—1950, $4.25

EYES AND INDUSTRY

By Hedwig S. Kuhn, M.D., *Department of Industrial Psychology at Purdue University*—The C. V. Mosby Company, 1940, $8.50

CANCER OF THE COLON AND RECTUM

By Fred W. Rankin, B.A., M.A., M.D., LL.D., ScD., F.A.C.S., *Surgeon, St. Joseph's and Good Samaritan Hospitals, Lexington, Kentucky*, and A. Stephens Grahm, M.D., M.S. (in Surgery), F.A.C.S., *Associate Professor of Surgery, Medical College of Virginia*—Charles C. Thomas, 1950, $7.50

THE ANTIHISTAMINES

By Samuel M. Feinberg, M.D., *Associate Professor of Medicine, Northwestern University*, Saul Malkeil, Ph.D., M.D., *Assistant Professor of Medicine, Northwestern University*, and Alan R. Feinberg, M.D., *Clinical Assistant in Medicine, Northwestern University*—The Year Book Publishers, Inc., 1950, $4.00

THORACIC SURGERY

By Richard H. Sweet, M.D., *Associate Clinical Professor Surgery, Harvard University Medical School*—W. B. Saunders Company, 1950, $10.00

ATLAS OF HUMAN ANATOMY

By Barry J. Anson, Ph.D., *Professor of Anatomy, Northwestern University Medical School*—W. B. Saunders Company, 1950, $11.50.

ANXIETY IN PREGNANCY AND CHILDBIRTH

By Henriette R. Klein, M.D., *Associate In Psychiatry, Columbia University College of Physicians and Surgeons*, Howard W. Potter, M.D., *Professor of Physchiatry, Long Island College of Medicine*, and Ruth B. Dyk, M.S., *Research Department, New York City Youth Board*—Paul B. Hoeber, Inc., 1950, $2.75

PRINCIPLES OF INTERNAL MEDICINE

By T. R. Harrison (Editor-in-Chief), M.D., *Southwestern Medical College;* with Paul B. Beeson, M.D., *Emory University Medical School;* William H. Resnik, M.D., *Stamford, Conn.;* George W. Thorn, M.D., *Harvard University Medical School;* M. M. Wintrobe, M.D., *University of Utah Medical College*—The Blakiston Company, 1950, $12.00

NURSING IN PREVENTION AND CONTROL OF TUBERCULOSIS

By H. W. Hetherington, M.D., M.R.C.P. (London), *Chief of Clinic of the Henry Phipps Institute of the University of Pennsylvania*, and Fannie W. Eshleman, R.N., B.S., *Supervisor of Public Health Nursing of the Henry Phipps Institute of the University of Pennsylvania.*—G. P. Putnam's Sons, 1950, $4.50

SEXUAL FEAR

By Edwin W. Hirsch, B.S., M.D., *Attending Urologist, Englewood Hospital, Chicago, Illinois*—Garden City Publishing Company, Inc., 1950, $3.00

BOOKS RECEIVED

PHYSICIAN'S HANDBOOK

By Marcus A. Krupp, M.D., *Assistant Clinical Professor of Medicine, Stanford University School of Medicine*, Norman J. Sweet, M.D., *Assistant Professor of Medicine, University of California School of Medicine, San Francisco*, Ernest Jawetz, Ph.D., M.D., *Associate Professor of Bacteriology and Lecturer in Medicine and Pediatrics, University of California School of Medicine, San Francisco*, Charles D. Armstrong, M.D., *Clinical Instructor in Medicine, Stanford University School of Medicine*—University Medical Publishers, 1950, $2.50

DISORDERS OF THE BLOOD

By Sir Lionel E. H. Whitby, M.D., F.R.C.P., D.P.H., *University of Cambridge;* and C. J. C. Britton M.D., D.P.H., *Bland Sutton Institute of Pathology, The Middlesex Hospital, London*—The Blakiston Company, 1950, $8.00

SIGNIFICANCE OF THE BODY FLUIDS IN CLINICAL MEDICINE

By L. H. Newburgh, M.D., *Professor of Clinical Investigation, University of Michigan Medical School, Ann Arbor Michigan*, assisted by Alexander Leaf, M.D., *Instructor in Internal Medicine, University of Michigan Medical School, Ann Arbor, Michigan*, Charles C. Thomas, 1950, 2.00

FREUD: DICTIONARY OF PSYCHOANALYSIS

Edited by Nandor Fodor, *Associate of the Association for the Advancement of Psychotherapy* and Frank Gaynor, *Co-Author of the "Dictionary of Industrial Psychology"*, with a preface by Theodor Reik, Author of "Listening With The Third *Ear*"—Philosophical Library, 1950, $3.75

NEW PRODUCTS

Micropellets Oreton-F (aqueous suspension of testosterone) intramuscular administration
Schering Corporation, Bloomfield and Union, N.J.

Chlor-Trimeton Maleate Syrup. Active Constituent: Chlorprophenpyridamine maleate. Administered orally.
Schering Corporation, Bloomfield, N.J.

Pyrabrom. (Chemical Composition not given in release)
Nelson Chesman Company, Chattanooga, Tenn.

Ampins. Now available in Ampins are: Luminal sodium, procaine penicillin aqueous suspension, procaine penicillin "G" with aluminum monostereate fortified, salyrgane-theophylline, and demerol.
Winthrop-Stearns, Inc., New York, N.Y.

Minacap Capsules. Vitamin and Mineral Therapy.
The Upjohn Company, Kalamazoo, Mich.

Mantrin. (Mannitol hexanitrate, rutin, phenobarbital) Administration orally (tablets)

Amoryn (water soluble mixture of conjugated estrogens or free estrogens extracted from pregnancy mare's urine) Administration orally (tablets).
The Paul Plessner Company, Detroit, Michigan

Tri-Sulphameth (Sulfadiazine, sulfamerazine, sulfamethazine and sodium citrate). Administration orally (syrup and tablets).
Casimir Funk, Inc., New York, N.Y.

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